

PATIENT REGISTRATION FORM

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

(please circle the best number to confirm your appointments)

Email Address (optional): _____

SSN: _____ Sex: F M Marital Status S M D W

Are you a full time student: Y N School Attending: _____

In case of an emergency, please notify:

Name: _____ Phone #: _____ Relationship to Patient: _____

INSURANCE AND POLICY HOLDER INFORMATION

PRIMARY Insurance Company: _____ Employer: _____

Policy Holder: _____ Date of Birth: _____ Contract#(SSN): _____ Group#: _____

SECONDARY Insurance Company: _____ Employer: _____

Policy Holder: _____ Date of Birth: _____ Contract#(SSN): _____ Group#: _____

Person responsible for this account: _____ Relationship to Patient: _____

How did you hear about us? Referral _____ Direct Mail Website Internet Sign

(please circle all that apply) (name of referral)

Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)

I, _____ have been given the opportunity to read a copy of this office's Notice of Privacy Practices.

Name: _____

Signature: _____

Date: _____

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Y N

If yes, please explain: _____

Have you taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Y N

What, if any, medications (including non-prescription medication) are you taking? _____

Do you have or have you had any of the following:

Table with 3 columns of medical conditions and checkboxes. Conditions include High Blood Pressure, Heart Disease, Chest Pains, Heart Attack, Cardiac Pacemaker, Easily Winded, Rheumatic Fever, Heart Murmur, Stroke, Swollen Ankles, Angina, Hay Fever/Allergies, Fainting/Seizures, Frequently Tired, Tuberculosis, Asthma, Anemia, Radiation Therapy, Anxiety, Emphysema, Cglaucoma, Epilepsy/Convulsions, Cancer, Recent Weight Loss, Leukemia, Arthritis, Liver Disease, Diabetes, Hepatitis/Jaundice, Respiratory Problems, AIDS or HIV Infection, Sexually Transmitted Disease, Mitral Valve Prolapse, Thyroid Problems, Stomach problems/Ulcers, Joint Replacement.

Are you allergic to or have had any reactions to the following:

Table with 2 columns of allergens and checkboxes. Allergens include Local Anesthetics (e.g. Novocain), Any Metals (mercury, nickel), Penicillin or other antibiotics, Latex Rubber, Sulfa Drugs, Sedatives, Barbituates, Iodine, Aspirin, Other.

Women Only: Are you pregnant? Y N

Are you nursing? Y N

DENTAL HISTORY

Name of Previous Dentist: _____ Date of Last Oral Exam: _____

Table with 2 columns of dental questions and checkboxes. Questions include Do your gums bleed while brushing or flossing?, Do you have frequent headaches?, Are your teeth sensitive to hot or cold?, Do you clench or grind your teeth?, Do you feel pain to any of your teeth?, Do you bite your lips or cheeks frequently?, Do you have sores or lumps in or near mouth?, Have you ever had difficult extractions?, Have you had head, neck or jaw injuries?, Do you wear dentures/partials?, Have you had orthodontic treatment?, Do you like your smile?

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous. I authorize my insurance company to pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents

(please sign)

WRITTEN FINANCIAL POLICY

Thank you for choosing Donald J. Kiss, D.D.S.. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable as possible by offering several payment options.

PAYMENT OPTIONS

- Cash, check, Visa, Mastercard, and Discover
- We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with case prior to completion of care.
- Convenient monthly payment plans from CareCredit

Please note:

Dr. Kiss requires payment at the time treatment is provided

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment.

A fee of \$50.00 is charged for patients who miss or cancel more than 2 times in a calendar year without 48 hour notice.

Donald J. Kiss, D.D.S. charges \$25.00 for returned checks.

If we do not receive payment from your insurance carrier for treatment provided, you will be responsible for payment

Patient, Parent or Gaurdian Signature

Print

Date